was obviously due to some extraneous causes, there remained but 3 cases in which there was any skin infection, which might be attributed to improper disinfection of the skin. From this analysis of his experience, McMullin believes this solution to be the most efficient for skin disinfection at our disposal at the present time. Healing under its use seems to take place more readily than under the iodine skin disinfection. McMullin believes that wound repair is accelerated by at least three days, when compared to that following the iodine skin disinfection. Applied to the skin of the hand, the solution is unirritating and is almost ideal as a skin disinfectant.

Sterilization of the Skin by McDonald's Solution.—STANTON (*Surg., Gynec., and Obst.*, 1915, xxi, 89) says that water, up to 10 per cent. or more, does not interfere with the action of the solution. Hence it is possible to use it on wet skin surfaces, such as those recently lathered for shaving, or the operator's hands after he has scrubbed them with soap and water. The solution is itself an excellent cleansing medium and so harmless that it can be used actually to scrub the patient, whereas tincture of iodine should not be rubbed in. It can be used before the patient is anesthetized without danger of complaint, as it is not irritating. It does not stain skin surfaces and dries very quickly, so that it is not necessary to protect peritoneal surfaces from contact with the skin, as in the case of iodine skin treatment. Stanton had only 2 infections in 240 otherwise clean cases, a record never before equalled in his work. During the year 1914 there was not one drop of pus collected in a clean case operated upon by him. Such results are significant and at least show that the method of skin preparation was efficient. Even more important was the fact that the wound healing was without evidence of chemical irritation, without peeling or blistering of the skin, and quite as rapid as that previously observed in simple alcohol-prepared incisions.

Pylephlebitis Complicating Appendicitis.—BABLER (*Ann. Surg.*, 1915, lxi, 589) says that formerly it was customary to regard perforative peritonitis as the most frequent and grave complication of appendicitis, but with the almost practical elimination of perforative peritonitis, he believes that the most grave complication is pylephlebitis with multiple abscesses of the lung or of the liver. In any given case the diagnosis must rest on (1) the history showing that the appendix was the primary seat of trouble, (2) the shifting of the symptoms from the appendix to the hepatic region, (3) the progressive increase in the severity and character of the symptoms, (4) the repeated chills followed by high pulse rate and marked elevation of body temperature, (5) the jaundice, (6) the persistent pain in the hepatic region, (7) the urinary and blood findings, (8) the change of liver dulness, (9) the picture of marked toxemia, and (10) the absence of the signs and manifestations of extensive peritonitis. The prognosis is necessarily grave. Prior to the work of Körte and Franke the complication was regarded as practically always fatal. The prognosis depends on (1) the size, multiplicity, and location of the abscesses, as well as their accessibility from a surgical stand-point, (2) the time of their discovery and (3) the general condition of the patient together with the character and time of the treatment. The treatment is outlined as follows: The appendix should be removed, the infected lymphatics leading from the appendix to the liver should be incised and drained, and the liver should be exposed and the abscesses located and drained. The abscess or abscesses in the lung must be located and drained. The intense pain will frequently guide the surgeon to the site of the abscesses. Babler does not feel that it is advisable to aspirate the liver until the latter has been duly exposed, unless preparations for immediate intervention have been completed. He strongly supports the lumbar drain in these cases.

The "Tongue-Depressor" Gastro-enterostomy Clamp.—GIBSON (*Ann. Surg.*, 1915, lxi, 604) illustrates a very simple clamp for gastric and intestinal anastomoses, consisting of three small pieces of wood, the ordinary wooden tongue-depressors, which are bound together by any suitable method, such as strong artery clamp, or, if more convenient, a sterile rubber band. These might be replaced by strips of cigar boxes. In his hands, both in experimental and clinical work, it has proven much more satisfactory than the Roosevelt, Bartlett, and other clamps used for this purpose. He has found it particularly satisfactory in doing a gastro-enterostomy, when it is desired to release the clamp in putting in the last mucous suture and the final peritoneal suture. Removing the rubber band allowed the tongue depressors to fall apart without further manipulation. By this method injury to the viscera is less likely to be produced. Two gastro-enterostomies and one entero-anastomosis have been successfully done with the aid of these clamps.

The Bone Graft Peg in the Treatment of Fractures of the Neck of the Femur.—ALBEE (*Ann. Surg.*, 1915, lxii, 85) says a large number of these fractures occur in individuals below the age of forty-five and fifty. The terms intracapsular and extracapsular are inaccurate and misleading and there is no object in classifying these fractures further than by the single term, "fractures of the neck." If any classification is used that of Stimson is by all means the best, *i. e.*, subcapital, or fracture through the neck, and fracture at the base of the neck. A strong autogenous bone peg, accurately fitted into a hole drilled longitudinally through the neck of the femur, with the fragments in good position, offers unquestionably the most ideal condition for the rapid and satisfactory union, in good position, of this fracture. The technic of the operation is as follows: The patient should be placed upon some traction table (Hawley) which will allow, simultaneously, abduction and traction. The point of the fracture is reached by an incision starting from a finger's breadth inside of the anterior superior spine and curved downward three to five inches along the inner border of the sartorius, which is retracted outward. The rectus femoris is retracted outward and the iliopsoas inward. All soft tissue is then cleared from between the fractured ends, which are curetted and freshened. The limb is now abducted and sufficient traction applied to bring the fragments into good apposition as determined by both sight and touch through the anterior wound. An incision two